ProtectTexas™
Texas Department of Health

TEXAS HIV MEDICATION PROGRAM - APPLICATION FOR ASSISTANCE

Mail To: ***Texas Department of Health***
Texas HIV Medication Program
1100 West 49th St., Austin, Texas 78756
1-800-255-1090 (512) 490-2510

PLEASE PRINT LEGIBLY - ALL QUESTIONS MUST BE COMPLETED. PROOF OF INCOME IS REQUIRED FOR ALL APPLICANTS.

The Texas HIV Medication Program (THMP) is a federal and state funded program for the qualified person with HIV-related conditions. Eligibility must be established prior to any provision of medication. The application must be completed in full. Any information given may need to be verified by providing documentation to the Program upon request.

I. APPLICANT INFORMATION: The applicant is the person for whom assistance is requested.

Full Name: (last, first, middle)	Date of Birth:	Sex: M ( ) F ( )
Residential Address **(REQUIRED)**: **(NO P.O. BOXES ACCEPTED)**	City:	Zip:
Mailing Address **(OPTIONAL)**: (if different from above)	City:	Zip:
Telephone: ( )	SSN#	
Parent or Guardian:	Relationship:	
Street Address: (If different from applicant's)	Race/Ethnicity ( )White ( ) African American ( )Hispanic ( ) Asian/Pacific Is. ( )Unknown ( ) Am.Indian/Alaskan	
Telephone: ( )		

TDH OFFICE USE ONLY

Medicaid #: Cov: Type:			Date Opened: Date Closed:	
Foodstamps: Yes No $			Date Opened: Active Denied Hold	
DOCCODE:	PHRCODE:			
RECD:	APPR:			

AZT	ZIAGN	KLTRA	SMZ-TMP	GANCI-IV
DDI	EMTRV	RYTAZ	DAPSN	GANCI-OR
DDI-EC	FORTO	LEXVA	PENTAM	VLCYT
DDC	INVIR	VIRMN	BIAXN	MEGEST
D4T	NORVR	RSCPT	ZITHR	MEPRON
3TC	CRXVN	SUSTI	SPRNX	MYAMBT
CMBVR	VRCPT	VIRAD	SPRNX-OR	MYCOB
TRIZ	AGNRS	ACYCL	DIFLU	

II. COMPLETE THE FOLLOWING FOR ALL PERSONS LIVING IN THE HOME (including applicant)

NAME	AGE	RELATIONSHIP
		(APPLICANT)

III. EMPLOYMENT AND INCOME INFORMATION

The sections on income and employment must include **all** of the family income if: the applicant is under 18 years of age and residing with parents, **OR**; the applicant is residing with a spouse and children. If neither of these conditions exist, information should be provided for the applicant only. **(Proof of income for the applicant and his/her spouse is required.) Employer and occupation information will be used for income verification only. EMPLOYERS WILL NOT BE CONTACTED.**

Are you or your spouse currently employed? ( ) Yes ( ) No

APPLICANT
Employer Name_____ Occupation _____

SPOUSE
Employer Name_____ Occupation _____

Family members whose incomes are considered are the applicant and his or her spouse. For minor children, the child's parents' incomes are considered.

Monthly Income		APPLICANT	SPOUSE	PARENTS
1.	Employment (Gross)	$	$	$
2.	Social Security (SSDI, SSI, etc.)	$	$	$
3.	Veteran's or Other Retirement Benefits or Pensions	$	$	$
4.	Public Assistance (Foodstamps, AFDC, etc.)	$	$	$
5.	Unemployment Compensation	$	$	$
6.	Worker's Compensation	$	$	$
7.	Other (please explain)	$	$	$

If any source of income is reported, copies of paystubs, W-2 forms, benefit entitlement letters, or other **PROOF OF STATED INCOME MUST BE ATTACHED TO THE APPLICATION**. If total of income in this section is zero, the attached Income Verification Form must be completed (page 4), along with a letter of explanation signed by the applicant explaining how he/she is able to live on zero income/cash assistance.

IV. INSURANCE INFORMATION

Do you have health insurance? ( )Yes ( )No Are prescription drugs covered? ( )Yes ( ) No

Name of company(ies)_____ Phone# (___)_____

Policy Number(s) _____

V. MISCELLANEOUS INFORMATION

Please give the name, address and phone number of your family physician or health care provider.

Is someone helping you fill out this form? ( ) Yes ( ) No If yes, please complete the following:

Name	Address (street, city, state, and ZIP)	Telephone
		(____)

The Texas HIV Medication Program establishes eligibility on the basis of medical condition, residency, and income according to the information provided in this application. **All questions must be answered or the application will be considered incomplete.** The Program may request verification of any information at any time. If notified to provide verification, the application will be placed on hold and Program approval withheld until such verification is received.

For residency verification, a copy of one of the following may be submitted: valid driver's license or identification card, motor vehicle or voter registration, or other documentation considered valid by the Program. For income verification, a copy of one of the following may be submitted: employer's written verification of gross monthly income, the most recent pay check stub/monthly employee earnings statement, Internal Revenue Service Form 1040 for the most recently completed year, pension/allotment award letters, or other verification considered valid by the Program.

This application is a legal document. The signature, when affixed, (1) attests that all the information given is true and correct, and (2) authorizes the release of medical information to the Texas Department of Health.

By signing this form, I affirm that the information contained in this application is true and correct. I understand that if I deliberately omit or give false information I can be removed from the Texas HIV Medication Program, or criminally prosecuted, or both.

Applicant's Signature:_____ Date:____/____/____
(REQUIRED)

PRIVACY NOTIFICATION / NOTIFICACIÓN SOBRE PRIVACIDAD

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.tdh.state.tx.us

Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la información que el Estado de Texas reúne sobre usted. A usted se le debe conceder el derecho de recibir y revisar la información al requerirla. Usted también tiene el derecho de pedir que la agencia estatal corrija cualquier información que se ha determinado sea incorrecta. Diríjase a http://www.tdh.state.tx.us para más información sobre la Notificación sobre privacidad. (Referencia: *Government Code,* sección 522.021, 522.023 y 559.004)

TEXAS HIV MEDICATION PROGRAM
INCOME VERIFICATION FORM

If applicant indicated an income of zero on page 2 of the application, this page should be completed along with a letter of explanation signed by the applicant explaining how he/she is able to live on zero income/cash assistance. Either Section I or Section II may be completed; completion of both sections is not required.

SECTION I. ASSISTANCE PROVIDED TO APPLICANT

This section must be completed by the person providing residence (room & board) and/or support.

I, (name of person providing residence and/or financial support) _____,

hereby certify that (name of applicant)_____

Check all that apply:

( ) Receives $ _____ a month from me as a regular contribution to his/her income.

( ) Is supported by me, in that I provide his/her housing, food, etc., and I do/do not(circle one) provide him/her with cash assistance.

By signing this form, I affirm that the above information is an accurate statement of assistance. I understand that if I deliberately omit or give false information the applicant can be removed from the Texas HIV Medication Program, or criminally prosecuted, or both.

_____

(signature of person providing residence/cash assistance) (phone) (date)

SECTION II. NO ASSISTANCE PROVIDED TO APPLICANT

This section must be completed by a social worker certified by the Texas State Board of Social Worker Examiners, or by a public health nurse. The social worker or public health nurse completing this section must be unrelated to the applicant and may not live in his/her household.

To the best of my knowledge neither _____ nor any member of (name of applicant)
his/her household has any cash income or receives any outside assistance (non-cash).

By signing this form, I affirm that the above information is an accurate statement of income. I understand that if I deliberately omit or give false information the applicant can be removed from the Texas HIV Medication Program, or criminally prosecuted, or both.

_____

(signature of social worker or public health nurse) (title)

_____

(agency/employer name) (address)

_____

(phone) (date)

TEXAS HIV MEDICATION PROGRAM
Authorization To Release Confidential Information

Client Name:_____ **SSN:**_____

Address:_____ **DOB:**_____

City, State:_____ **Zip:**_____

I authorize the Texas Department of Health, Texas HIV Medication Program, 1100 W.49th Street, Austin, Texas 78756, to release the following specific confidential information:

Financial Information: Yes( ) No( ) Indicate Specific Information:_____

Medical Information: Yes( ) No( ) Indicate Specific Information:_____

HIV-Related Information: Yes( ) No( ) Indicate Specific Information:_____

Other: Yes( ) No( ) Indicate Specific Information:_____

to the following individual:

Name of Individual (required)_____

Organization:_____

Address:_____

City, State:_____ **Zip:**_____

The information released may be used by the individual, or the organization represented by the individual, for the following purposes:

<u>This authorization is in effect until I revoke it in writing, which I may do at any time.</u>

This form was ( ) read by me or, ( ) was read to me, and I understand its meaning. All the blanks were filled in before the form was signed by me. I have signed this form voluntarily.

Signature_____ **Date:**_____

_____ / _____

(Print name of person authorized to consent to release of information) **(signature of authorized person)**

_____

(relationship to client) **(address)** **(telephone)**

TEXAS HIV MEDICATION PROGRAM
MEDICAL CERTIFICATION FORM

(TO BE COMPLETED BY PHYSICIAN) **Texas HIV Medication Code (if known)** _____

The information on this form is necessary to determine the patient's eligibility for program-supplied, HIV-related therapy as prescribed by you. All information on this form will be kept strictly confidential by the Texas Department of Health. Personal identifying information is never released.

PATIENT INFORMATION

Full Name: _____

Mailing Address: _____ Apt. # _____

City, State, Zip: _____ Phone # ( ) _____

Date of Birth: ____/____/____ Social Security Number: _____
Month Day Year

*****NOTICE*** Changes in therapy after initial approval and/or recertification may be faxed to (512) 490-2503.**

I hereby certify that this patient has been diagnosed with HIV infection, and I am reporting the following viral load and CD4 count:

Plasma RNA Viral Load:	Test Date:	**Current CD4 Count:**	**Test Date:**
_____ **copies/ml**	/ /		/ /

PRESCRIBED MEDICATIONS FOR OPPORTUNISTIC INFECTIONS:

_____ **Pentamidine** } For CD4 ≤ 200, or thrush, or
_____ **SMZ/TMP** } previous PCP diagnosis, or
_____ **Dapsone/TMP** } unexplained fever>100º for >2 weeks
_____ **Acyclovir,** for acute or chronic herpetic infection
_____ **Itraconazole capsules** (Sporanox), for diagnosed histoplasmosis or blastomycosis
_____ **Clarithromycin** (Biaxin), for a current or previous mycobacterium avium complex (MAC) diagnosis, OR
_____ **Azithromycin** (Zithromax), if client failed therapy on, or is intolerant of, clarithromycin
_____ **Fluconazole** (Diflucan), for diagnosed cryptococcal meningitis or esophageal candidiasis, OR
_____ **Itraconazole suspension** (Sporanox), for diagnosed esophageal candidiasis
_____ **Ganciclovir** (Cytovene), for diagnosed CMV disease with infection(s) of major organ(s) or organ system(s), OR
_____ **Valganciclovir** (Valcyte), for diagnosed CMV disease with infection(s) of major organ(s) or organ system(s)
_____ **Megesterol Acetate** (Megace), for diagnosed cachexia or anorexia with profound, involuntary, acute weight loss ≥10% of baseline body weight or chronic weight loss ≥20% of baseline body weight
_____ **Atovaquone** (Mepron), for diagnosed acute, mild to moderate PCP and intolerance to both SMZ-TMP and dapsone
_____ **Rifabutin** (Mycobutin), for a CD4 cell count ≤ 100
_____ **Ethambutol** (Myambutol), for a current or previous mycobacterium avium complex (MAC) diagnosis

*****REQUIRED***** Is this patient naïve to antiretroviral therapy? (check one) _____ Yes _____ No

PRESCRIBED ANTIRETROVIRAL MEDICATIONS: LIMIT OF FOUR (4) ANTIRETROVIRALS MAX PER CLIENT

_____ **zidovudine** (AZT, Retrovir)
_____ **didanosine** (DDI, Videx)
_____ **zalcitabine** (DDC, Hivid)
_____ **stavudine** (D4T, Zerit)
_____ **lamivudine** (3TC, Epivir)
_____ **abacavir sulfate** (Ziagen)
_____ **Combivir** (AZT/3TC)*
_____ **Trizivir** (AZT/3TC/Ziagen)*
_____ **emtricitabine** (Emtriva)
_____ **Truvada** (Emtriva/Viread)*
_____ **Epzicom** (3TC/Ziagen)*

_____ **fortovase** (saquinavir)
_____ **invirase** (saquinavir)
_____ **ritonavir** (Norvir)
_____ **indinavir** (Crixivan)
_____ **nelfinavir** (Viracept)
_____ **amprenavir** (Agenerase)
_____ **lopinavir/ritonavir** (Kaletra)
_____ **atazanavir** (Reyataz)
_____ **fosamprenavir** (Lexiva) – boosted dosage, 1bottle/mo (recommended)
_____ **fosamprenavir** (Lexiva) – unboosted dosage (2 bottles/month without low-dose ritonavir); requires consultation with THMP Physician.

_____ **nevirapine** (Viramune)
_____ **delavirdine** (Rescriptor)
_____ **efavirenz** (Sustiva)

_____ **tenofovir** (Viread)

Please note: *For the 4 antiretroviral limit, Combivir , Truvada & Epzicom each count as 2 antiretrovirals; Trizivir counts as 3 antiretrovirals.

PHYSICIAN SIGNATURE: _____ TX MD/DO LICENSE #: _____

PRINTED NAME OF PHYSICIAN: _____

OFFICE ADDRESS: _____

TELEPHONE: _____ DATE ____/____/____